2005 Short Plan Year Open Enrollment Guide

Colorado Department of Personnel & Administration

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This guide and the accompanying materials are provided as an overview of the 2005 short plan year group benefit plans offered to State of Colorado employees and their eligible dependents. The group benefit plans include medical, dental, life insurance, Health and Dependent Care Flexible Spending Accounts, Short-Term Disability, Long-Term Disability, and Tax Deferred Savings plans. These enrollment materials do not constitute a binding contract with employees and/or dependents and the State of Colorado. Every effort was made to ensure the accuracy of the information contained in these materials.

The terms and conditions of the State's group benefit plans are controlled by the Group Master Contracts, plan documents, the State Benefit Plans chapter of the State Personnel Director's Administrative Procedures (Chapter 11), and Employee Benefits written directives. In the event of a conflict with federal regulations and state statutes, the governing laws will prevail. A copy of the administrative procedures is maintained and available for review through your agency payroll or benefits administrator, and on the Division of Human Resources website **www.colorado.gov/dpa/dhr**.

The plans offered by the State are intended and expected to continue, however, the State reserves the right to discontinue or revise these plans at any time. In addition to this guide, other methods of communication such as memos, meetings, newspaper articles, direct mail and electronic media, are used to help keep you informed. For questions prior to enrolling in any of the State's group benefit plans, contact each carrier directly at the phone number listed on the last page of this guide or consult with your agency payroll, or benefits, administrator. Once you have enrolled, direct your questions to the appropriate carrier(s).

There have been changes, so it is critical that you review this guide carefully and make benefit decisions that best meet your needs and the needs of your dependents. Please keep in mind that once you enroll, you may not be able to make changes until the next open enrollment period.

Fraud

It is unlawful for any employee, employee's dependent(s), or other individual(s) to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application or claim for group benefits. Penalties may include imprisonment, fines, denial for or termination of enrollment in any or all of the State's group benefit plans, civil damages, or as provided in regulations, statutes, and written directives.

Warning: If you are insured under a separate group medical insurance policy, you may be subject to coordination of benefits as explained in this booklet. This includes health and dental insurance.

2005 Short Plan Year Open Enrollment runs from October 18 through November 6, 2004. You can access the On-line Enrollment System during this time period by clicking on the Open Enrollment link at **www.colorado.gov/dpa/dhr/benefits/2005**. This link will only be active during the open enrollment period.

This guide contains all the materials needed to help you make informed choices for your 2005 short plan year benefits. **This year it is especially important that you** carefully review rates, compare plan descriptions, calculate flexible spending account (FSA) deductions, and consider your tax status using the resources provided. Pre-tax may affect your highest average salary (HAS) for PERA purposes. Once elected for the plan year, FSA deductions and tax status can only be changed under very limited circumstances (see Exceptions to Irrevocability Rules for the few exceptions).

If you want to re-enroll in an FSA, change your pre-tax or after-tax deductions, change dependents' coverage, or had PacifiCare HMO and want to continue medical coverage, you must use the on-line system to make these or any other changes to your coverage. If you have no changes for the 2005 short plan year, you will be re-enrolled in your current plans. State personnel system employees working in the CU system MUST use CU's open enrollment process.

The Employee Benefits unit has researched options for employees who do not have Internet access at their homes or work and has compiled a list of resources for those employees. That list includes dates, times, and locations of community colleges throughout the State where employees will be provided Internet access to enroll. The list is available in the Appendix of this guide. Additionally, public libraries offer internet access to the public.

All of the following materials will also be available at any time from within the On-line Open Enrollment System by simply clicking "Resources."

The State of Colorado offers a variety of health care plan options designed to meet individual health care and financial needs. The State of Colorado offers the statewide and regional options listed below to eligible employees.

PacifiCare HMO is no longer offered for 2005. Employees who had PacifiCare HMO and want to continue medical coverage for 2005 MUST use the On-line Enrollment System to enroll in another State-offered plan.

Carefully review and compare rates, plan changes, and health plan descriptions for 2005 when making your decisions. Medical health plan descriptions can be found separately at **www.colorado.gov/dpa/dhr** as Medical Description Forms.

Statewide Plans:
Anthem Liberty EPO
Anthem Centennial PPO

Regional Plans:
Kaiser Permanente HMO
San Luis Valley HMO

Plans	Carrier Premium Rates	State Contribution	Subtotal Employee Cost	State Administration Fee	Total Employee Cost
Anthem Liberty EPO					
Employee	$ 343.06	**$ 178.06**	$ 165.00	$ 3.30	**$ 168.30**
Employee +1	$ 686.08	**$ 303.50**	$ 382.58	$ 3.30	**$ 385.88**
Family	$ 960.50	**$ 420.02**	$ 540.48	$ 3.30	**$ 543.78**
Anthem Centennial PPO					
Employee	$ 218.94	**$ 178.06**	$ 40.88	$ 3.30	**$ 44.18**
Employee +1	$ 437.90	**$ 303.50**	$ 134.40	$ 3.30	**$ 137.70**
Family	$ 613.08	**$ 420.02**	$ 193.06	$ 3.30	**$ 196.36**
Kaiser HMO					
Employee	$ 258.06	**$ 178.06**	$ 80.00	$ 3.30	**$ 83.30**
Employee +1	$ 516.16	**$ 303.50**	$ 212.66	$ 3.30	**$ 215.96**
Family	$ 722.64	**$ 420.02**	$ 302.62	$ 3.30	**$ 305.92**
San Luis Valley HMO					
Employee	$ 261.86	**$ 178.06**	$ 83.80	$ 3.30	**$ 87.10**
Employee +1	$ 523.68	**$ 303.50**	$ 220.18	$ 3.30	**$ 223.48**
Family	$ 733.46	**$ 420.02**	$ 313.44	$ 3.30	**$ 316.74**

Anthem Centennial PPO
The in-network deductibles will go down from $2000 to $1000 for an individual, and from $4000 to $2000 for a family; the out-of-network deductibles also will be reduced from $4000 to $2000 for an individual, and from $8000 to $4000 for a family. The in-network out-of-pocket annual maximums will decrease from $5000 to $2500 for an individual, and from $10,000 to $5000 for a family; the out-of-network annual maximums will be reduced from $10,000 to $5000 for an individual, and from $20,000 to $10,000 for a family. Preventive care frequency schedules (e.g., one physical per year or one exam per two years) will be removed for the short plan-year. For physical, occupational and speech therapies, the annual number of visits has been increased to 20 for each type (versus aggregate) of therapy. Wigs are now covered as durable medical equipment at 80% after the deductible for those suffering hair loss due to specified reasons. Private duty nursing coverage is now excluded unless services are billed by a home health or hospice agency and approved as part of a treatment plan.

Anthem Liberty EPO
The out-of-pocket annual maximums will be reduced from $2000 to $1000 for an individual, and from $6000 to $3000 for a family. Preventive care frequency schedules (e.g., one physical per year or one exam per two years) will be removed for the short plan-year. For physical, occupational and speech therapies, the annual number of visits has been increased to 20 for each type (versus aggregate) of therapy. Wigs will be covered as durable medical equipment at 80% as part of the $3000 DME maximum payment. Private duty nursing coverage is now excluded unless services are billed by a home health or hospice agency and approved as part of a treatment plan.

Kaiser Permanente HMO
There are no changes for the 2005 short plan year.

San Luis Valley
There are no changes for the 2005 short plan year.

Why is PacifiCare no longer offered?
In addition to extremely high proposed premium increases with a reduction in benefits, PacifiCare HMO proposed several requirements in their renewal offer that the State could not agree to, such as: a guaranteed number of enrollments; specified employer contribution level; their own definition of employee eligibility; payment of premium in advance; and the right to change rates during the plan year. Thus, the decision was made not to renew the State's contract with PacifiCare. The Employee Benefits staff is working with PacifiCare to ensure a smooth transition to another plan for its members, specifically those who are currently in treatment or may be in case management at the end of the plan year (December 31, 2004). If you currently have PacifiCare HMO and you wish to have the State's medical insurance in 2005, you **must** choose another medical carrier using the On-line Enrollment System.

The State currently offers two dental plans: Delta Basic and Delta Basic Plus. The State pays the premium for its eligible employees. Employees who wish to add dependents or upgrade to the Delta Basic Plus plan are responsible for paying the difference in rates.

Employees can also purchase dental coverage for their eligible dependents. Dependent children under the age of five are covered through the employee's plan at no cost to the employee for both Delta Basic and Delta Basic Plus. Dependents under five still must be listed as such on the dental benefit enrollment form.

The no cost coverage for children under age five automatically terminates the end of month the child turns five. If the employee wishes to continue the child's coverage after he or she turns five, the employee MUST complete a new enrollment change form regardless of coverage level and submit to the appropriate department's payroll or benefits staff before the end of the month in which the child turns five.

Statewide Plans
Delta Basic
Delta Basic Plus

Plans	Carrier Premium Rates	State Contribution	Total Employee Cost
Delta Dental Basic Plan			
Employee	$16.26	$16.26	**$0.00**
Employee +1	$36.92	$16.26	**$20.66**
Family	$58.00	$16.26	**$41.74**
Delta Dental Basic Plus Plan			
Employee	$24.34	$16.26	**$8.08**
Employee +1	$53.90	$16.26	**$37.64**
Family	$100.48	$16.26	**$84.22**

Please pay close attention to the following changes to the State's dental plans.

Delta Dental Basic
The coverage for basic services, endodontics, oral surgery and periodontics has increased to 70%. The per family member per benefit plan year deductible has been reduced to $25.

Delta Basic Plus
The lifetime maximum for orthodontic services for dependent children up to age 19 has increased to $1500, and adult orthodontic services will now be covered at a rate of 50% with a $1500 lifetime maximum. The per person per benefit plan year deductible has been reduced to $25, and the per family per benefit plan year deductible has been reduced to $75, regardless of the number of dependents.

The State of Colorado has a non-duplication of benefits clause in its Group Master Contract with Delta. Non-duplication of benefits means Delta will not duplicate any benefit it would have normally paid were it the primary insurance. With non-duplication (also known as "Carve Out"), Delta will subtract the benefits paid by the primary insurance carrier from the benefits that Delta would have normally paid (benefits less benefits). If a balance remains, Delta will pay that amount.

Example #1

Total charge: $500.00
Delta would normally pay 50% or $250.00
Primary insurance paid $250.00
Subtract the amount the primary insurance paid from the amount Delta would have normally paid. ($250.00 less $250.00 = 0). The benefit to be paid by Delta as the secondary carrier is $0.

Example #

Total charge: $500.00
Delta would normally pay 50% or $250.00
Primary insurance paid $200.00
Subtract the amount the primary insurance paid from the amount Delta would have normally paid. ($250.00 less $200.00 = $50.00). The benefit to be paid by Delta as the secondary carrier is $50.00.

If this Delta Plan is primary, as provided above, it shall provide benefits without to what is provided by another Plan. If this Plan is secondary and the plan year maximum has been reached by the primary carrier, Delta would then begin to pay as if it were the primary carrier (or until the Plan Year Benefit Maximum is reached under this Delta plan or the plan year ends, whichever comes first).

Delta Preferred Option Plan***BASIC***
Group #006784

EFFECTIVE JANUARY 1, 2005

MAXIMUM: Per enrolled family member per benefit plan year $850.00	**DEDUCTIBLE:** $25.00 per family member per benefit plan year deductible. The deductible is waived for Diagnostic and Preventive Services.
PREVENTIVE AND DIAGNOSTIC SERVICES	
• **DPO: 100%** • **NON-DPO: 100%** (of maximum allowable fee)	**Oral Exam:** 2 in a benefit plan year **Bitewing X-rays: 2** sets in a benefit plan year **Full Mouth X-rays:** 1 in 36 months **Routine Cleaning:** 2 in a benefit plan year **Fluoride Treatments:** 2 in a benefit plan, under age **15** **Space Maintainers:** under age **19** **Sealants:** under age **15** on unrestored, noncarious permanent molars, but not more than once in any 36 month period Emergency treatment for relief of pain
BASIC SERVICES	
• **DPO: 70%** • **NON-DPO: 70%** (of maximum allowable fee)	**Restorative:** Amalgam Fillings Resin, Composite Fillings (anterior teeth only) **Oral Surgery:** Simple Extractions, Surgical Extractions (including wisdom teeth), General Anesthesia **Periodontics:** Periodontal Cleanings (subject to special need), Periodontal Surgery (including gingivectomy), Scaling and Root Planing, Gingival Curettage **Endodontics:** Root Canal Therapy
MAJOR SERVICES	
• **DPO: 50%** • **NON-DPO: 50%** (of maximum allowable fee)	**Major Restorative:** Crowns, Inlays, and Onlays - when teeth cannot be restored with regular fillings **Prosthodontics:** Dentures, Partials, Fixed Bridges and Crowns (when part of the bridge) **Prosthodontics Maintenance:** Bridge or Denture Repair, Rebase or Reline of Dentures, Re-cement of Crowns, Inlays and Onlays

Dependent Children covered to the end of year in which the child attains age 19
Full-time Students covered to the end of the month in which the child attains age 24

During Open Enrollment, employees will have the opportunity to switch between plans. Dependents under age five are covered under the dental plan at no premium cost to the employee. During the month a dependent reaches age five, the child must be added to the employee(s) dental coverage (even if already at family) and pay premium in order to continue coverage.

This is just a brief description of the dental plan designed for the State of Colorado.
IMPORTANT: YOU WILL PAY ADDITIONAL OUT OF POCKET EXPENSES WHEN YOU SEE A NON-DPO DENTIST!

MAXIMUM ALLOWABLE FEE IS BASED ON A PRE-ARRANGED DISCOUNTED FEE SCHEDULE.

Delta Preferred Option Plan***BASIC PLUS***
Group #006785

EFFECTIVE JANUARY 1, 2005

MAXIMUM: Per enrolled family member per benefit plan year: $1,200.00, Orthodontic Lifetime Max: $1,500.00	**DEDUCTIBLE:** $25.00 per person per benefit plan year; $75.00 per family. Th deductible is waived for Diagnostic, Preventive and Orthodontia.

PREVENTIVE AND DIAGNOSTIC SERVICES	
• **DPO: 100%** • **NON-DPO: 100%** (of maximum allowable fee)	**Oral Exam:** 2 in a benefit plan year **Bitewing X-rays: 2** sets in a benefit plan year **Full Mouth X-rays:** 1 in 36 months **Routine Cleaning:** 2 in a benefit plan year **Fluoride Treatments:** 2 in a benefit plan year, under age **15** **Space Maintainers:** under age **19** **Sealants:** under age **15** on unrestored, noncarious permanent molars, but not more than once in any 36 month period Emergency treatment for relief of pain
BASIC SERVICES	
• **DPO: 80%** • **NON-DPO: 80%** (of maximum allowable fee)	**Restorative:** Amalgam Fillings Resin, Composite Fillings (anterior teeth only) **Oral Surgery:** Simple Extractions, Surgical Extractions (including wisdom teeth), General Anesthesia **Periodontics:** Periodontal Cleanings (subject to special need), Periodontal Surgery (including gingivectomy), Scaling and Root Planing, Gingival Curettage **Endodontics:** Root Canal Therapy
MAJOR SERVICES	
• **DPO: 50%** • **NON-DPO: 50%** (of maximum allowable fee)	**Major Restorative:** Crowns, Inlays, and Onlays - when teeth cannot be restored with regular fillings **Prosthodontics:** Dentures, Partials, Fixed Bridges and Crowns (when part of the bridge) **Prosthodontics Maintenance:** Bridge or Denture Repair, Rebase or Reline of Dentures, Re-cement of Crowns, Inlays and Onlays
ORTHODONTICS	
• **50%**	Complete Orthodontic Exam (including necessary x-rays) Active Orthodontic Treatment. Orthodontic benefits provided for all eligible employees and dependents

Dependent Children covered to the end of year in which the child attains age 19
Full-time Students covered to the end of the month in which the child attains age 24

During Open Enrollment, employees will have the opportunity to switch between plans. Dependents under age five are covered under the dental plan at no premium cost to the employee. During the month a dependent reaches age five, the child must be added to the employee(s) dental coverage (even if already at family) and pay premium in order to continue coverage.

This is just a brief description of the dental plan designed for the State of Colorado.
IMPORTANT: YOU WILL PAY ADDITIONAL OUT OF POCKET EXPENSES WHEN YOU SEE A NON-DPO DENTIST!

MAXIMUM ALLOWABLE FEE IS BASED ON A PRE-ARRANGED DISCOUNTED FEE SCHEDULE.

Employees who want to change from pre-tax to post-tax or visa versa must use the On-line Enrollment System to do so. Employees will be able to choose pre-tax and post-tax options separately for both dental and medical insurance. **Mid-year changes from pre-tax to post-tax and visa versa are not permitted.**

Pre-tax premiums do affect your highest average salary (HAS) with PERA. Thus, employees within three years of PERA retirement should carefully consider pre-tax contributions to a Flexible Spending Account.

Consider Pre-tax or After-tax Deductions
If you select medical and/or dental coverage, you may elect to have your share of the premium deducted on a pre-tax basis under the premium conversion provisions of the State's Section 125 Salary Reduction Plan. Your take-home pay will be greater because federal and State income taxes, your PERA contribution, and the Medicare Tax (where applicable) will be based on your reduced salary. The higher your income tax bracket, the greater your savings will be.

How Section 125 Affects PERA Benefits
Your disability and retirement benefits through the Public Employees Retirement Association (PERA) are based on the average of your three highest annual salaries. Since PERA contributions are calculated as a percentage of salary, the monthly contributions to your PERA account are reduced to the extent that your salary is reduced by pre-tax premium contributions. PERA benefits are affected when the pre-tax premium option is selected during the three years of HAS, but are not be affected by selecting the pre-tax premium option in other years. In other words, if the salaries used to calculate your HAS are from periods in which you participated in the Section 125 Salary Reduction Plan, the PERA benefit amount paid to you will be lower than if you were not participating in the plan.

Review your Selection Annually
If you elect the pre-tax premium option, your election will continue automatically from year to year unless you change your option during the regularly scheduled annual open enrollment period. **Mid-year or retroactive election changes are not permitted.** If you are within three years of retirement, take time to consider whether or not you should participate in the Section 125 Salary Reduction Plan. For more information about how Section 125 salary reductions affect your PERA benefits, call PERA Customer Service at 303-832-9550 or 1-800-759-7372.

Pre-tax Premium Elections are Irrevocable during the Plan Year
If you choose the pre-tax premium option, your election is generally irrevocable during the plan year. Refer to *Exceptions to the Irrevocability Rules* at **www.colorado.gov/dpa/dhr/benefits/2005** for information regarding the limited circumstances under which you may be permitted to change your election. If you wish to retain the option to cancel your coverage during the plan year, do not elect pre-tax premium. Keep in mind that if you choose the post-tax option, the only mid-year change allowed is cancellation of coverage.

Important Note: To enable the change to a fiscal year plan year, the State of Colorado Salary Reduction Plan document has been amended to provide for a transitional, six-month plan year (also called the "short plan year" or "period of coverage") of January 1, 2005, through June 30, 2005. The term "plan year" as used in the following section also refers to this six-month plan year. The term "annual election" also means the total contribution for the six-month plan year. During this transitional period only, the maximum annual election (contribution) for a Health Care FSA is $3000, for a Dependent Care FSA $2500.

What is a flexible spending account and how can it help me control my health care costs?
An FSA allows you to set aside money on a pre-tax basis, lowering your taxable income. You can then use that money to cover health care and dependent care expenses. An FSA will not directly lower or control your health care costs, but using an FSA will put more money in your pocket to pay for those costs.

Flexible spending accounts are funded by salary reductions, commonly referred to as "contributions." You choose the amount you wish to "contribute" each year. This amount is also called your annual election. Your payroll deduction is calculated by dividing your annual election by the number of paychecks you receive in a year. You must make separate elections for your health care flexible spending account and your dependent care flexible spending account.

Central Bank/ASI administers the State's FSA plans. You may want to view ASI's website at **www.asiflex.com**. There is a great deal of detailed information published there, although not all of the information on ASI's site applies to the State's plan. Participants may check the status of their flexible spending accounts from the ASI website using the PIN provided on their enrollment confirmations. Alternatively, accounts may be accessed via telephone at 1-800-366-4827. At the prompt, press 2 for balance or disbursement information. Press 1 to speak with a representative.

Are all medical expenses eligible for reimbursement?
No, but most medical expenses not reimbursed by insurance can be reimbursed from your health care flexible spending account. Any expense that qualifies under Section 213(d) of the Internal Revenue Code (except insurance premiums and long-term care expenses) qualifies. You may download Internal Revenue Publication 502 Medical and Dental Expenses from the IRS website **www.irs.gov/pub/irs-pdf/p502.pdf**. The list of eligible expenses changes over time. If you have not reviewed the list recently, you may want to take another look.

Please note that while the IRS requires expenses be "paid" within the tax year (calendar year) to be deductible, expenses must be "incurred" during the plan year in order to be eligible for reimbursement from a flexible spending account. IRS rules around deductions for income tax purposes are different.

Important Note: The State's Salary Reduction Plan Document was amended and restated effective June 1, 2004. The plan now allows reimbursement of over-the-counter drugs to treat an existing or imminent medical condition.

Claims Procedures applicable to Over-the-Counter Drugs and Medicines

- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- The participant must indicate the existing or imminent condition on the receipt, on the claim form or on a separate enclosed Statement each time these items are claimed. Purchases for general good

health will not be accepted.
- To claim vitamins, herbs, or nutritional supplements, you must have a written diagnosis of the medical condition and "prescription" of all specific items for that condition on file with the claims office. You must renew this physician notice every 12 months and file it with the claims office with the first claim submitted for these each plan year.

Non-Qualifying Over-the-Counter Medicines and Drugs

Items purchased for general health purposes are not covered. Such non-qualifying items include but are not limited to:
- Vitamins
- Herbs
- Nutritional Supplements
- Cosmetic Supplies (e.g., blemish cream)
- Large supply of qualifying items, not for existing or imminent condition
- First aid supplies and medical staples, not for existing or imminent condition (e.g., aspirin, antacid, antiseptic, camphorated oil, etc., purchased to have on hand)
- Band-Aids, plasters or other non-medicines
- General hygiene items (toothpaste, floss, medicated foot powder, dandruff shampoo, deodorant, etc.)

Are all dependent care expenses eligible for reimbursement?
No, but expenses that qualify under Internal Revenue Code Section 21(b)(2) for the Child Care Credit will qualify for reimbursement. If you pay someone to care for a child under the age of 13 or for a family member that cannot care for himself or herself (e.g., a disabled or elderly adult tax dependent) so you can work, the cost of care may be reimbursed from your dependent care flexible spending account. Download Internal Revenue Publication 503 Child and Dependent Care Expenses - **http://www.irs.gov/pub/irs-pdf/p503.pdf** - for more information. If you file for the childcare tax credit with your tax return, you may still be eligible to participate in the dependent care flexible spending account, depending upon your income level and the amount of care expenses you expect to incur. You may want to consult your tax advisor before making an election.

Please note that while the IRS requires expenses be "paid" within the tax year (calendar year) to be deductible, expenses must be "incurred" during the plan year in order to be eligible for reimbursement from a flexible spending account. IRS rules around deductions for income tax purposes are different.

How much can I save?
The amount you can save depends upon your tax bracket and the amount of your election. If, for example, your combined federal and State income tax rate is 22%, you will save approximately $22 in taxes per $100 of annual election.

Account balances are forfeited at the end of the year. Why can't the money be returned to me?
Flexible Spending Accounts are subject to IRS Section 125 rules and regulations. Under current law, an employer is prohibited from refunding or carrying over an individual's flexible spending account balance from one plan year to the next. Also, it may not be returned since once the money is contributed, by law, the contribution becomes the plan's money and not the individual's.

My wife experienced complications during childbirth and our out-of-pocket expenses were much greater than expected. Can we increase our election to cover the extra expense?
You may increase your election within 31 days of the birth, but your reimbursement will be limited to the annual election in place when the expense was incurred. For example, if your monthly contribution to your Health Care FSA was $100 prior to the birth, you could be reimbursed for no more than $1200 for expenses incurred prior to the date your election is increased.

Can I change my election during the plan year?
If you participate in the Flexible Spending Account program, your election is generally irrevocable during the plan year, **meaning you cannot make changes**. Refer to the State's Salary Reduction Plan Document for information regarding the limited circumstances under which you may be permitted to change your election.

Are there any other rules and regulations I should know about?
Since salary reductions reduce your taxes, the IRS has established certain rules that Flexible Spending Account programs must follow.

- To be considered for reimbursement, health care expenses must be incurred during the plan year (January 1 through June 30, 2005) while you are participating in the plan. "Incurred" is defined as the date on which services are provided, not when you are formally billed or pay the expense.
- To be considered for reimbursement, dependent care expenses must be used for care incurred during the plan year (1/1/05 - 6/30/05).
- Unused contributions cannot be carried forward or returned to you. If your eligible, incurred expenses are less than your contributions during the plan year, the unused funds are forfeited.
- Contributions are not transferable from one account to another. The funds must be kept separate. Funds in a Dependent Care FSA cannot be used to reimburse health care expenses and vice versa.
- "Double-dipping" is not permitted. Expenses reimbursed from your Health Care FSA cannot be claimed as a deduction when filing an itemized tax return.
- Expenses reimbursed from your Dependent Care FSA cannot be used for federal child care tax credit.
- To be considered, your reimbursement request must be postmarked no later than October 15 following the end of the plan year (June 30, 2005).

Central Bank /ASI is under contract with the State to provide administrative services for the FSA program. ASI offers the option of having reimbursements deposited directly into your checking or savings account (Direct Deposit) and the option of receiving notices via e-mail. See **http://www.asiflex.com** for additional information.

	Health Care FSA	Dependent Care FSA
What is the Maximum Contribution for the short plan year?	$3000 (for the six-month plan year)	If single, the lesser of the Participant's earned income for the year or $2500 If married, the lesser of the Participant's or the Spouse's earned income for the year or $2500 if filing jointly, $1250 if filing separately.
○ **Special Rule if Spouse is Full-time Student**	Not applicable	For each month during which spouse is a full-time student, spouse shall be considered to be gainfully employed and earning income of not less than $250 per month if there is one Eligible Dependent with respect to the Participant, or $500 per month if there are two or more Eligible Dependents with respect to the Participant.
○ **Special Rule if Spouse is Incapable of Self-Care.**	Not applicable	For each month during which spouse is incapable of caring for him/herself, spouse shall be considered to be gainfully employed and earning income of not less than $250 per month if there is one Eligible Dependent with respect to the Participant, or $500 per month if there are two or more Eligible Dependents with respect to the Participant.
What is the Minimum Monthly Benefit? (note: to accommodate bi-weekly payroll, monthly contributions must be an even number, round down as needed)	$10	$10

What kinds of Expenses may be reimbursed from my Flexible Spending Account?	Medical care, as defined in Section 213(d) of the Internal Revenue Code, **excluding** (i) premiums for any health insurance plan, policy or contract, or (ii) long-term care expenses and (iii) any expense which has been reimbursed, or is reimbursable from any other source [see www.asiflex.com for discussion of eligible medical expenses]. Expense must also be excludable from income pursuant to IRC Section 129. Expense must be incurred during the Short Plan Year and in a month during which a contribution is made. Expense must be incurred by Participating Employee or Eligible Dependent.	Dependent care expenses for the care of an Eligible Dependent, limited to the household and dependent care services necessary for gainful employment as provided in IRC Section 21(b)(2) in accordance with IRC Section 129 [see www.asiflex.com for discussion of eligible dependent care expenses]. Expense must be incurred during the Short Plan Year and in a month during which a contribution is made. Expenses incurred in any month in which the Employee or Spouse is not gainfully employed are not eligible.
Definition of "Eligible Employee"	The definition found in statutes (see Appendix, page 52). Employee does not include persons employed on a temporary basis.	Same as Health Care FSA
Definition of "Eligible Dependent"	The spouse and each unmarried child or step-child of a participating Employee, or any other relative or household member whom the Participant may claim as a dependent for federal income tax purposes in accordance with IRC Section 152 for the Plan Year in which eligible expenses are incurred.	Same as Health Care FSA. An Eligible Dependent must also qualify as a "qualifying individual" as specified in IRC Section 21(b)(1).
How do I file a request for reimbursement?	Submit a request for reimbursement (claim form) and documentation. to ASI, P.O. Box 6044, Columbia, MO 65205-6044.	Same as Health Care FSA

What kind of documentation is required?	An Explanation of Benefits from Insurance Carrier, or an Itemized Bill from Provider that includes: Date of Service Amount of Charge Description of Service Provider Name and Tax ID Additional information as may reasonable be required to adjudicate the claim.	Same as Health Care FSA
Where can I get a Claim Form?	Download from www.asiflex.com.	Download from www.asiflex.com
Can coverage be continued under COBRA?	Yes, if on the date of the qualifying event, there is a positive balance in the account (contributions exceed reimbursements). Coverage under COBRA may be continued through the end of the Short Plan Year, subject to timely remittance of contribution and administration fees.	No
What is the deadline for submission of claims?	Complete claims must be postmarked not later than October 15, 2005, following the end of the Short Plan Year. [1]	Same as Health Care FSA
What is the Maximum Benefit?	100% of unreimbursed, eligible medical expenses, not to exceed Participant's Annual Contribution for the Plan Year	100% of eligible dependent care expenses, not to exceed the balance available in the account at any given time.

[1] The deadline for submission of reimbursement requests for expenses incurred in the 2004 Plan Year is April 15, 2005.

Health Care Worksheet

Estimating your health care expenses

* Enter your health care expenses for the last 12 months.
* Enter your known or expected expenses for the next 6 months.

Eligible Expenses	Expenses Incurred in 2004	Expected Expenses January through June of 2005
Health Care Expenses:		
Deductibles	$	$
Coinsurance	$	$
Copayments	$	$
Amounts above plan limits	$	$
Other health care expenses not reimbursed by your medical plan	$	$
Dental Expenses:		
Deductibles, copayments	$	$
Coinsurance	$	$
Other dental expenses not reimbursed by your dental plan	$	$
Vision & Hearing Expenses (above plan maximums):		
Eye exams	$	$
Corrective contact lenses	$	$
Prescription eyeglasses	$	$
Hearing exams	$	$
Hearing aids or devices	$	$
TOTAL EXPENSES	**$**	**$**
Note: For monthly amount for 2005 Short Plan Year, divide by 6	$	$

Note: Only expenses incurred during the short plan year may be reimbursed. You will need to enroll again for the next plan year starting 7/1/05.

The State now provides $33,000 of Basic Life and Accidental Death and Dismemberment (AD&D) coverage at no cost to you. You may also apply for up to $300,000 of Optional Life and AD&D coverage for yourself in $10,000 increments. And, if you apply for Optional Life and AD&D, you may also apply for up to $10,000 Children Optional Life and AD&D coverage in $5,000 increments. The employee must have at least $20,000 of Optional Life in order to purchase the $10,000 maximum for children.

Insurance Amount	Under 20	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70 & Over
$10,000	0.76	0.80	0.84	1.04	1.16	1.40	2.00	3.18	5.18	9.62	15.84	28.30
$20,000	1.52	1.60	1.68	2.08	2.32	2.80	4.00	6.36	10.36	19.24	31.68	56.60
$30,000	2.28	2.40	2.52	3.12	3.48	4.20	6.00	9.54	15.54	28.86	47.52	84.90
$40,000	3.04	3.20	3.36	4.16	4.64	5.60	8.00	12.72	20.72	38.48	63.36	113.20
$50,000	3.80	4.00	4.20	5.20	5.80	7.00	10.00	15.90	25.90	48.10	79.20	141.50
$60,000	4.56	4.80	5.04	6.24	6.96	8.40	12.00	19.08	31.08	57.72	95.04	169.80
$70,000	5.32	5.60	5.88	7.28	8.12	9.80	14.00	22.26	36.26	67.34	110.88	198.10
$80,000	6.08	6.40	6.72	8.32	9.28	11.20	16.00	25.44	41.44	76.96	126.72	226.40
$90,000	6.84	7.20	7.56	9.36	10.44	12.60	18.00	28.62	46.62	86.58	142.56	254.70
$100,000	7.60	8.00	8.40	10.40	11.60	14.00	20.00	31.80	51.80	96.20	158.40	283.00
$110,000	8.36	8.80	9.24	11.44	12.76	15.40	22.00	34.98	56.98	105.82	174.24	311.30
$120,000	9.12	9.60	10.08	12.48	13.92	16.80	24.00	38.16	62.16	115.44	190.08	339.60
$130,000	9.88	10.40	10.92	13.52	15.08	18.20	26.00	41.34	67.34	125.06	205.92	367.90
$140,000	10.64	11.20	11.76	14.56	16.24	19.60	28.00	44.52	72.52	134.68	221.76	396.20
$150,000	11.40	12.00	12.60	15.60	17.40	21.00	30.00	47.70	77.70	144.30	237.60	424.50
$160,000	12.16	12.80	13.44	16.64	18.56	22.40	32.00	50.88	82.88	153.92	253.44	452.80
$170,000	12.92	13.60	14.28	17.68	19.72	23.80	34.00	54.06	88.06	163.54	269.28	481.10
$180,000	13.68	14.40	15.12	18.72	20.88	25.20	36.00	57.24	93.24	173.16	285.12	509.40
$190,000	14.44	15.20	15.96	19.76	22.04	26.60	38.00	60.42	98.42	182.78	300.96	537.70
$200,000	15.20	16.00	16.80	20.80	23.20	28.00	40.00	63.60	103.60	192.40	316.80	566.00
$210,000	15.96	16.80	17.64	21.84	24.36	29.40	42.00	66.78	108.78	202.02	332.64	594.30
$220,000	16.72	17.60	18.48	22.88	25.52	30.80	44.00	69.96	113.96	211.64	348.48	622.60
$230,000	17.48	18.40	19.32	23.92	26.68	32.20	46.00	73.14	119.14	221.26	364.32	650.90
$240,000	18.24	19.20	20.16	24.96	27.84	33.60	48.00	76.32	124.32	230.88	380.16	679.20
$250,000	19.00	20.00	21.00	26.00	29.00	35.00	50.00	79.50	129.50	240.50	396.00	707.50
$260,000	19.76	20.80	21.84	27.04	30.16	36.40	52.00	82.68	134.68	250.12	411.84	735.80
$270,000	20.52	21.60	22.68	28.08	31.32	37.80	54.00	85.86	139.86	259.74	427.68	764.10
$280,000	21.28	22.40	23.52	29.12	32.48	39.20	56.00	89.04	145.04	269.36	443.52	792.40
$290,000	22.04	23.20	24.36	30.16	33.64	40.60	58.00	92.22	150.22	278.98	459.36	820.70
$300,000	22.80	24.00	25.20	31.20	34.80	42.00	60.00	95.40	155.40	288.60	475.20	849.00

Employee/Spouse Optional Life/AD&D Premiums by Insurance Amount and Age

Above premiums are individual premiums. If you select coverage for both you and your spouse, the total premium amount will be the cost for you plus the cost for your spouse.

Note: Spouse coverage limited to not more than half of Employee coverage, up to $150,000.

Optional Life/AD&D Insurance Plan Rates for Dependent Children

One monthly premium covers all of your eligible children for the Optional Life insurance amount selected. This coverage must be cancelled when your last eligible dependent child reaches the maximum age. A child may not be insured by more than one member, except in the event the members are divorced from each other. Double coverage is not allowed.

Plans	Coverage Amount	Total Employee Cost
Plan 05		
Child: Birth to 19 years (24 if full-time student)	$ 5,000	**$ 1.24**
Plan 010		
Child: Birth to 19 years (24 if full-time student)	$ 10,000	**$ 2.48**

The State's Group Term Life and AD&D coverages are underwritten by Standard Insurance Company. The benefits are substantially the same as in the current Basic Life and Optional Life plans except for the increase in Basic Life from $12,000 to $33,000. The Certificate of Coverage is available on-line for your review.

Why isn't Guarantee Issue offered at open enrollment anymore?
The State's prior practice of offering Guaranteed Issue at open enrollment caused adverse selection against the plan and increased premiums. By limiting Guarantee Issue, the State is able to hold down the Optional Life rates. Guarantee Issue means you apply for an amount of life insurance coverage and are *guaranteed* the amount applied for without proof of insurability, such as a medical history statement. Adverse selection means selecting a particular benefit when there is a current or clearly foreseeable need for such a benefit.

Will Guarantee Issue be available at all?
Not during open enrollment. Employees who apply within 30 days of their initial eligibility (date of hire) will be offered the opportunity to purchase up to $60,000 of Optional Life and up to half of that amount ($30,000) for their spouses without evidence of insurability. Guarantee Issue also applies when an employee applies for Optional Life within 31 days of acquiring a dependent by marriage, birth or adoption, or applies within 31 days of the death of a spouse. Amounts applied for in excess of the Guaranteed Issue amount are subject to approval of your medical history.

Why is spouse coverage limited?
When we analyzed death claims, it was apparent that claims for spouses were disproportionately greater than for employees. By limiting spouse coverage to 50 percent of employee coverage, we feel we can balance the risk by encouraging healthy employees who might not otherwise enroll to do so. We did not want to eliminate Guarantee Issue altogether.

My spouse currently has Optional Life insurance. Can she keep it, or do I now have to apply?
Current levels of coverage are "grandfathered" but upgrades (or downgrades) will be subject to the new rules. By way of example, assume you and your spouse currently each have $20,000 of Optional Life. You may keep it that way if you choose, but if your spouse now wants to apply for $50,000, you must apply for and be issued at least $100,000, subject to medical history approval.

My spouse is healthy, but I am not. What if I am not approved for additional coverage?
Your spouse will not be issued more than half of the amount issued to you even if he or she is healthier than you.

Active at Work Provisions
If you are incapable of active work because of sickness, injury or pregnancy on the day before your scheduled effective date, your life insurance coverage will not become effective until the day after you complete one full day of active work as an eligible Member. See the Active-at-Work Provisions in the Certificate of Coverage.

Is my Group Term Life and AD&D benefit taxable?
You may be taxed on a portion of the value of your Group Term Life insurance (Basic and Optional Life), but only to the extent that the "imputed value" (see below) of your coverage (as determined in accordance with IRS rules) exceeds the actual premium.

The value of the first $50,000 is tax exempt. Because the IRS uses age at the end of the year to determine imputed value, while the State uses age at the beginning of the year to determine

EMPLOYEE	
Basic Life and AD&D	**$33,000** **State pays 100%**
Optional Life and AD&D	**Up to $300,000 in $10,000 increments** **Employee pays 100%** **Proof of Insurability Required**
SPOUSE	
Optional Life and AD&D	**Up to $150,000 in $10,000 increments, but not more than half of the amount issued to Employee.** **Employee pays 100%** **Proof of Insurability Required**
CHILDREN	
Optional Life and AD&D	**Up to $10,000 in $5,000 increments** **Employee must also be enrolled in Optional Life**

Basic Life and AD&D
The State provides $33,000 of Basic Life and Accidental Death and Dismemberment (AD&D) coverage at no cost to you. Enrollment is not required; coverage is automatic. However, if you wish to designate a beneficiary, you must submit a beneficiary designation either on-line or on a hard copy form given to your payroll or benefits office. In the absence of a valid beneficiary designation, proceeds will be paid in accordance with the order of precedence in the Certificate of Coverage.

Employee/Spouse Optional Life and AD&D Coverage
You may apply for up to $300,000 of Optional Life and AD&D coverage for yourself in $10,000 increments. In the event of accidental death, your beneficiaries will receive twice the face amount. If you apply for Optional Life and AD&D for yourself, you may also apply for up to half of the face amount issued to you for your spouse, in $10,000 increments. Your coverage must be approved for your spouse's coverage to be approved.

Premiums are based upon the age of each insured. The State's Optional Life plan is not part of the Salary Reduction Plan. Premiums contributions do not reduce your taxable income and do not affect your PERA benefits. The death benefits are not taxable as income.

To apply, or change your coverage, you must complete the enrollment/change form. Your coverage is subject to approval of medical history and verification of eligibility. Approval is not guaranteed. If you enroll, you will receive a Medical History Statement by mail for each adult applicant to complete and mail to:

Standard Insurance Company
Medical Underwriting
900 SW Fifth Avenue
Portland, OR 97204-1282

If approved, coverage will be effective the first of the month following approval by the carrier, subject to the Active- at-Work (defined on page 37) provisions of the policy.

Dependent Children Optional Life and AD&D
If you apply for Optional Life and AD&D you may also apply for up to $10,000 Children Optional Life and AD&D coverage in $5,000 increments, not to exceed half of the amount issued to you. One monthly premium covers all of your eligible children, including full-time students up to age 24 and disabled dependent children. You may apply for Dependent Children Life and AD&D within 31 days

after your initial eligibility (date of hire), during open enrollment, or within 31 days after a Life Change Event (marriage, birth, adoption, or death of spouse).

Guaranteed Issue
Evidence of Insurability is not required under the following circumstances.

1) You are enrolled in the Basic Life / AD&D Plan only.
2) You are applying for no more than $60,000 for yourself and $30,000 for your spouse within 31 days after your initial eligibility (date of hire).
3) You are applying for no more than $60,000 for yourself and $30,000 for your spouse within 31 days after a Life Change Event (marriage, birth, adoption, or death of spouse).
4) You have Optional Life coverage for yourself already and you are applying for Children's coverage only.

When Guaranteed Issue applies, coverage will be effective on the date of hire, or date of marriage, birth or adoption, subject to the Active-at-Work provisions (defined on page 37)of the policy. Premiums will be payable from the first of the month following your date of hire or Life Change Event, providing your application is timely.

Double Coverage Is Not Allowed
If your spouse is also a State employee, you may elect to be covered as an employee or as a spouse, but not both. Only one of you may apply for coverage for your children. If you are divorced and your former spouse is also a State employee, both of you may elect Optional Dependent Life and AD&D for your children.

Certificate of Coverage
The Certificate of Coverage, which encompasses both Basic and Optional Life plans, is available at **www.colorado.gov/dpa/dhr/benefits/2005**.

Beneficiary Designations
If your insured spouse or child dies, the life insurance benefits will be payable to you, if you are living. If you are not living, the benefits will be paid to the survivors in accordance with the policy provisions. You may name more than one beneficiary in a class (primary or secondary). The beneficiary designation applies to both the Basic Life and Optional Life benefits under the policy. If only one beneficiary in a class survives, that beneficiary will receive all of the death benefit. A secondary (contingent) beneficiary receives benefits ONLY if there are no surviving primary beneficiaries.

See the Benefit Payment and Beneficiary Provisions in the Certificate of Coverage for additional information.

Waiver of Premium
If you are not yet 60 years of age and become totally disabled, your life insurance may be continued without payment of premiums after completion of a 180 consecutive day waiting period. If you are receiving disability benefits from Standard Insurance Company under the State's Short-Term Disability or Long-Term Disability plans, the waiver of premium benefit will be applied automatically. If you are not receiving disability benefits under the State plan, you must submit an application for waiver of premium benefits. Proof of total disability will be required. See the Waiver of Premium Provisions in the Group Term Life / AD&D Certificate of Coverage for a complete description of the benefit.

Portability of Benefits
Upon termination of employment, you may be eligible to purchase portable group insurance coverage for yourself and your insured dependents without evidence of insurability. To be eligible, you must

have been continuously covered the plan (or prior plan) for at least 12 consecutive months, must be able to work, and under the age of 65. An application for portability benefits must be submitted to Standard Insurance Company with the first premium payment within 31 days after termination of employment. Coverage is provided under a separate policy to the Standard Insurance Company Group Insurance Trust and will contain provisions that differ from the State's Group Term Life Policy. Contact Standard Life Insurance Company for the rates. See the Portability of Insurance Provisions in the Certificate of Coverage.

Accelerated Benefit
If you are terminally ill and eligible for Wavier of Premium, you may be eligible to receive up to 75% of the insurance while still living. Medical proof of terminal condition is required. See the Accelerated qualifies for Waiver of Premium Benefit Provisions in the Certificate of Coverage for details.

Right to Convert
You may be eligible to purchase an individual policy of life insurance without Evidence Of Insurability if your coverage ends or is reduced for any reason other than a) failure to pay the premium when due, or b) payment of an accelerated benefit. Contact Standard Life Insurance Company for the rates. Application must be made within 31 days after the loss of coverage. See the Right to Convert Provisions in the Certificate of Coverage for options and limitations.

How to Change your Beneficiary
You may change your beneficiary designation at any time by submitting a new Beneficiary Designation on-line. The on-line system makes a note of the time and date. To be valid, you must personally make the designation. A designation made on your behalf by payroll or benefits staff is invalid.

If you prefer, you may download a hard copy of the Beneficiary Designation to complete, date, and sign. If you use a hard copy, it must be returned to your administrator while you are living. All hard copy enrollment forms and beneficiary designations are maintained at your department's payroll or human resources office.

Canceling Coverage
You may cancel your Optional Life coverage anytime on-line or by submitting a hard copy change form to your payroll or benefits office. Your coverage will terminate the last day of the month in which you cancel coverage or terminate employment. You must cancel Spouse Optional Life coverage within 31 of a final divorce decree. Coverage for dependent children must be cancelled within 31 days of the date your last child becomes ineligible.

Leave of Absence
You may continue your Optional Life and AD&D during a period of unpaid leave by remitting the premium to your payroll or benefits staff. If your coverage lapses for non-payment of premium, you must wait until the next open enrollment to reapply. Proof of insurability will be required. Your Basic Life and AD&D will be continued during a period of approved, unpaid leave of absence at no cost to you.

Disability coverage helps protect a portion of your income if you are disabled due to a covered illness, pregnancy, or injury. The State of Colorado provides state-paid Short-Term Disability (STD) coverage. Employees can also purchase Long-Term Disability (LTD). Premiums for LTD are based on employee salary, age, and vesting status.

State of Colorado employees who have at least five years of PERA-covered employment can also purchase disability insurance through the PERA disability program. The Employee Benefits unit provides a comparison chart of the State and PERA programs to help employees find the coverage appropriate for their needs.

Optional Long-term Disability Rates

Your monthly premium is determined by the calculation below, using your age, your base monthly salary, and whether or not you are vested in PERA.

$ _____	X _____	= $ _____
Base Monthly Salary	Factor (age group/vested or non-vested)	Monthly Employee Cost

Example: The amount for a non-vested employee, age 37, with base salary of $3000/month would be $21.60 a month. ($3000 X .0072 = $21.60)

Employee Age as of January 1, 2005	PERA Vested	PERA Non-vested
Under 30	0.0017	0.0048
30-34	0.0020	0.0059
35-39	0.0025	0.0072
40-44	0.0033	0.0102
45-49	0.0051	0.0154
50-54	0.0076	0.0229
55-59	0.0106	0.0338
60-64	0.0115	0.0346
65+	0.0140	0.0420

	State of Colorado		PERA	
	STD	**LTD**	**STD**	**Disability Retirement**
Who is eligible?	State employees based on CRS 24-50-603(7). To purchase LTD coverage, an employee must work at least 30 hours a week.		Employees who have earned five years of PERA service credit (state troopers, CBI agents and judges are eligible immediately).	
Does the employer pay for the program?	Yes	No, optional coverage available to employees for a premium, based on age, salary & vested status.	Yes, pre-funded through monthly employer contributions to PERA.	
When does coverage begin?	From the first day of active employment.	After approval from Standard Ins. Co. & first payroll deduction is taken.	Once an employee becomes vested with PERA.	
How do I apply for disability benefits?	Apply through department payroll or benefits staff within 30 days of absence.	STD claim serves as LTD application.	Contact **PERA's Customer Service Center** to request a Disability Program brochure (includes an application and summary plan description).	
What is the benefit waiting period?	30 calendar days or state requirement for exhaustion of sick leave, whichever is later.	180 calendar days from date of disability or exhaustion of sick leave, whichever is later.	60 calendar days or state requirement for exhaustion of sick leave, whichever is later.	None.
What is the maximum benefit period?	150 days in a consecutive 12-month period = 180 days minus the 30 calendar day waiting period.	If enrolled, covered up to age 65.	Up to the first 22 months after the payment waiting period.	Lifetime, if disability continues.
How is the disability benefit calculated?	60% of pre-disability earnings based on gross weekly earnings, less deductible income, prior to disability.		60% of pre-disability PERA-includable salary (gross pay minus IRC Sec. 125 deductions) less deductible income.	Usually, 50% of **HAS**; however, it may be more or less depending upon age and service credit.
What are the maximum/minimum payments?	Max: $2,310/wk less deductible income. Min: none	Max: $10,000/month less deductible income. Min: $100.	Calculated benefits may be reduced by certain deductible income.	None.

Summary of Tax-Deferred Savings Plans Offered to State Employees

Plan Name	Retirement	Supplemental	DB	DC
PERA 401a	Yes		Yes	
PERA 401k		Yes		Yes
State of Colorado 457 Plan		Yes		Yes
State Defined Contribution Plan *	Yes			Yes
403b (Higher Education only)		Yes		Yes

Definitions

In general terms, the difference between a defined contribution (DC) plan and a defined benefit (DB) plan, such as PERA, is as follows.

- **DC plan** - Your total retirement benefit is equal to your total accumulated account balance or the amount that has been contributed by you and your employer plus any income or gains, and minus any expenses or losses [e.g., State DC Plan, 457, 401(k)].

- **DB plan** - Your total retirement benefit under a defined benefit plan is based on number of years of service, your age and your highest average salary. With this information, a monthly benefit is calculated that you will receive for the rest of your life. Unlike the DC plan, the total benefit is not directly based on how much was contributed on your behalf.

- **Retirement Plan** - A plan that provides benefits, after retirement, from a trust or other separately maintained fund, by the purchase of insurance, or from general assets (unfunded plan). The amount of benefits is either specified or calculated in accordance with a set formula based on factors such as age and service.

- **Supplemental Tax-Deferred Savings Plan** - An optional plan that provides benefits to employees in addition to regular retirement benefits. Supplemental benefits vary according to the terms of each plan and include such items as the payment of benefits in the event of terminations, death, disability or early retirement.

(*) Eligibility for this plan as of 01/01/05 is, "'Eligible employee' means a member of the general assembly, the governor, the lieutenant governor, the attorney general, the chief deputy attorney general, the solicitor general, the secretary of State, the deputy secretary of State, the State treasurer, the deputy State treasurer, a district attorney, an assistant district attorney, a chief deputy district attorney, a deputy district attorney, or other employee of a district attorney, a member of the public utilities commission and an executive director of a department of State appointed by the governor, an employee of the senate or house of representatives, and a non-classified employee of the office of the governor, for whom a defined contribution plan has been established pursuant to the provisions of this article" [C.R.S. 24-52-202].

All State employees automatically participate in the defined benefit plan under the Public Employees Retirement Association (PERA). State employees have several additional easy ways to supplement their PERA retirement. You can choose the State's 457 Deferred Compensation Plan, PERA's 401k program, or one of the 403(b) tax-deferred annuity plans if you are employed by higher education. Elected and appointed officials have an option to choose between the State Defined Contribution Retirement Plan and PERA.

IRS Codes	*457*	*401k*	*403(b)*
Minimum contribution	$25 per month	None	Contact plan
Maximum contribution	$14,000 in 2005 $15,000 in 2006 Then increased in $500 increments.	$14,000 in 2005 $15,000 in 2006 Then increased in $500 increments.	$14,000 in 2005 $15,000 in 2006 Then increased in $500 increments.
Catch-up provision	For the 3 consecutive years prior to retirement, you can contribute up to twice the available limit.	Not available	With 15 years of service you may contribute up to $13,500 for 3 consecutive years.
Catch-up for participants age 50 & over (This is a combined limit between the 401(k) and 403(b).)	Participants age 50 and over may make additional contributions of $4,000 in 2005 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments. (1)	Participants age 50 and over may make additional contributions of $4,000 in 2005 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments. (1)	Participants age 50 and over may make additional contributions of $4,000 in 2005 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments. (1)
Loans	One loan per account balance for any reason. (4)	Up to two loans at any time for any reason.	May be possible; contact plan administrator.
Distributions	Separation from service, retirement, disability, de minimus.	Age 59 1/2 , retirement, disability, separation from service. (2)	Age 59 1/2, retirement, disability, separation from service. (2)
Active Service Withdrawal	Unforeseeable emergency. (4)	Financial hardship or after age 59 1/2	Financial hardship or after age 59 1/2
Purchase service credit	Yes (4)	Yes	Yes
Rollover Provisions	Rollovers between 457, 401(k), 403(b), IRA. (3)	Rollovers between 457, 401(k), 403(b), IRA. (3)	Rollovers between 457, 401(k), 403(b), IRA. (3)
Penalty on early withdrawals before age 59 1/2	No	Yes, unless rolled over to another tax-deferred account, life time monthly payments, or an exception applies.	Yes, unless rolled over to another tax-deferred account, life time monthly payments, or an exception applies.
Plan fees	Investment management fees plus $9 annual fee assessed quarterly ($2.25); no fee for new participants for first year.	Investment management fees plus $18 annual fee assessed monthly ($1.50). New participants also pay $12 annual fee assessed monthly ($1.00).	Contact plan .
Commission, or load fees.	None	None	Contact plan

(1) This is a combined limit between 401(k) and 403(b) plans. Over-age 50 catch-up cannot to be used at the same time as the traditional catch-up.
(2) All withdrawals are subject to ordinary income tax. A 10% federal tax penalty may apply to withdrawals made prior to age 59 1/2.
(3) Any monies rolled over from a 457 to any other plan may be subject to the 10% federal tax penalty for withdrawals made prior to age 59 1/2.
(4) The employer match was suspended effective May 2004, SB04-132. 457 participants with match account balances may still apply for a loan, hardship or purchase service credit.
Note: This is only a summary. The actual terms of the above noted Plans are governed by the legal plan documents and federal and State law. Any inconsistencies between this summary and the plan documents or federal and State law, the plan documents and federal and State law will prevail.

Open enrollment for those who have continued their coverage under (COBRA) will be from November 8, 2004, to November 27, 2004. This open enrollment will be done on-line and will not use paper forms. Information regarding on-line open enrollment, instructions, 2005 rates and plan changes will be sent to the homes of those currently under COBRA in mid-October. Additionally, the information will be available on our website at **www.colorado.gov/dpa/dhr/benefits/2005**.

This will be a passive enrollment, meaning that if you do not wish to make any changes, your current choices will roll forward into whatever portion of 2005 your COBRA eligibility extends. **Please remember that PacifiCare HMO will not be offered in the State plans for 2005. Thus, if you have PacifiCare HMO and you wish to continue coverage under the State plans through COBRA, you must use the On-line Enrollment System** to select another plan. If you do not choose another plan, you will not have coverage in 2005.

The annual COBRA Open Enrollment period also permits you to add eligible dependents to your existing medical or dental coverage. Dependents enrolled during this open enrollment period, except for newborns and adopted children, are **NOT considered qualified beneficiaries**. This means that these dependents who are added during the open enrollment period would lose medical or dental coverage under COBRA if the original qualified beneficiary, whom they are a dependent of, were to lose coverage. Qualified beneficiaries are those individuals covered by one of the State's health plans at the time of the employee's qualifying event. Also, dependents added to a COBRA medical or dental plan during the open enrollment period shall only have eligibility for the balance of time remaining from the original COBRA qualifying event date.

For example, let us assume a dependent was eligible for 18 months of COBRA coverage at the time of the qualifying event, but did not elect to continue coverage at that time. Six months later, during the COBRA Open Enrollment, this dependent is added to the COBRA coverage under a covered qualified beneficiary. This dependent's COBRA eligibility now extends only for the remaining 12 months of the original qualified beneficiary's 18-month eligibility.

If you will experience a COBRA qualifying event during October, November, or December of 2004, you will need to make a selection for the remainder of 2004. If you wish to make changes for 2005, you will need to participate in on-line open enrollment. The timing of your qualifying event determines whether you will participate in the employee on-line open enrollment or the COBRA on-line open enrollment.

For those who will experience a **COBRA qualifying event in October or November of 2004, up to November 27**, you will need to make COBRA elections for the remainder of 2004 using the "COBRA Election Form" that will be mailed to you as part of your COBRA packet. If you wish to make changes for 2005, you will need to participate in the on-line COBRA open enrollment, November 8 2004, through November 27, 2004.

For those who will experience a **COBRA qualifying event after November 27, 2004, or in December of 2004** (thus losing coverage as of December 31st) but who currently have coverage as employees or dependents of employees, please note that if you wish to make changes for 2005, you will need to participate in the on-line employee open enrollment, October 18, 2004, through November 7, 2004, NOT the COBRA open enrollment. Your elections during that time will then become your COBRA coverage starting January 1, 2005. Whether making changes for 2005 or not, you will still need to use the paper "COBRA Election Form" that will be sent to you as part of your COBRA packet. Simply indicate the same plan as you chose in the on-line system.

2005 SHORT PLAN YEAR COBRA MONTHLY RATES

The chart below reflects the 2005 Short Plan Year COBRA Monthly Rates for the medical and dental plans listed.

Medical Plans		Empl. Only	Empl + One	Empl. + 2/More
Anthem Liberty EPO	Contract Rate	$343.06	$686.08	$960.50
	2% Admin Fee	$6.86	$13.72	$19.21
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$353.22**	**$703.10**	**$983.01**
Anthem Centennial PPO	Contract Rate	$218.94	$437.90	$613.08
	2% Admin Fee	$4.38	$8.76	$12.26
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$226.62**	**$449.96**	**$628.64**
Kaiser HMO	Contract Rate	$258.06	$516.16	$722.64
	2% Admin Fee	$5.16	$10.32	$14.45
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$266.52**	**$529.78**	**$740.39**
San Luis Valley HMO	Contract Rate	$261.86	$523.68	$733.46
	2% Admin Fee	$5.24	$10.47	$14.67
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$270.40**	**$537.45**	**$751.43**
Delta Dental Plans		**Empl. Only**	**Empl + One**	**Empl. + 2/More**
BASIC Plan - A	Premium	$16.26	$36.92	$58.00
	2% Admin Fee	$0.33	$0.74	$1.16
	Total	**$16.59**	**$37.66**	**$59.16**
BASIC PLUS Plan - B	Premium	$24.34	$53.90	$100.48
	2% Admin Fee	$0.49	$1.08	$2.01
	Total	**$24.83**	**$54.98**	**$102.49**

2005 COBRA DISABILITY EXTENSION RATES

Months 19 - 29

The chart below reflects the 2005 COBRA Disability Monthly Rates for the medical and dental plans listed.

Medical Plans		Empl. Only	Empl + One	Empl. + 2/More
Anthem Liberty EPO	Contract Rate	$343.06	$686.08	$960.50
	50% Admin Fee	$171.53	$343.04	$480.25
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$517.89**	**$1,032.42**	**$1,444.05**
Anthem Centennial PPO	Contract Rate	$218.94	$437.90	$613.08
	50% Admin Fee	$109.47	$218.95	$306.54
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$331.71**	**$660.15**	**$922.92**
Kaiser HMO	Contract Rate	$258.06	$516.16	$722.64
	50% Admin Fee	$129.03	$258.08	$361.32
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$390.39**	**$777.54**	**$1,087.26**
San Luis Valley HMO	Contract Rate	$261.86	$523.68	$733.46
	50% Admin Fee	$130.93	$261.84	$366.73
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	**$396.09**	**$788.82**	**$1,103.49**
Delta Dental Plans		**Empl. Only**	**Empl + One**	**Empl. + 2/More**
BASIC Plan - A	Premium	$16.26	$36.92	$58.00
	50% Admin Fee	$8.13	$18.46	$29.00
	Total	**$24.39**	**$55.38**	**$87.00**
BASIC PLUS Plan - B	Premium	$24.34	$53.90	$100.48
	50% Admin Fee	$12.17	$26.95	$50.24
	Total	**$36.51**	**$80.85**	**$150.72**

The 2005 short plan year open enrollment runs from October 18 to November 6. Detailed 2005 plan descriptions, rates, and other important information to help you make your benefits choices are available at **www.colorado.gov/dpa/dhr/benefits/2005 (under Benefits)**. A summary of your current benefits is included with this mailing. **Please review the summary of your current benefits before going further.** If the information with your summary is inaccurate, contact your department's benefits or payroll administrator. State personnel system employees with the University of Colorado **MUST** use CU's on-line system for open enrollment.

I have reviewed the summary of my current benefits and want to make no changes for 2005. Do I have to use the on-line system?

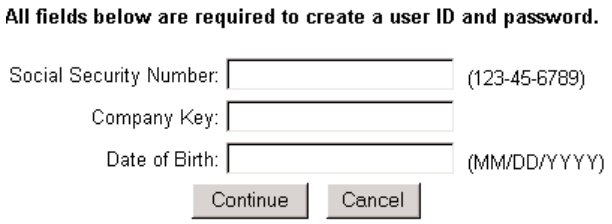
If you have no changes for the 2005 short plan year, you will be automatically re-enrolled in your current benefits plans, and you do not have to use the on-line system, unless:

- You participate in a Health or Dependent Care Flexible Spending Account, and you want to re-enroll for 2005.
- You participate in PacifiCare HMO (this plan is no longer available in 2005) and you want to continue medical coverage for the 2005 short plan year.
- You want to change your pre-tax or post-tax status (electing pre-tax status will lower your highest annual salary for PERA purposes).

These three exceptions are considered changes, and you **MUST** use the on-line system to make them. If none of these changes apply, your current coverages will be defaulted for the 2005 short plan year.

I want to make changes for the 2005 short plan year. How do I use the on-line system?

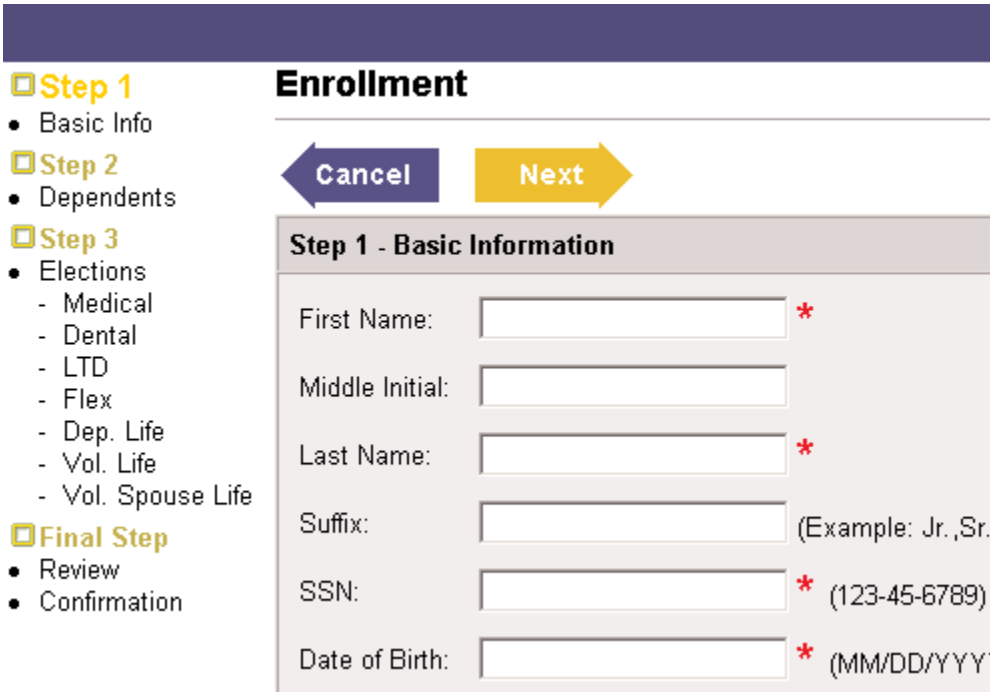
Remember that open enrollment is from October 18 to November 6. During this time, go to **www.colorado.gov/dpa/dhr/benefits/2005 (under Benefits)**. Click on **2005 Open Enrollment**. You will be taken to a welcome screen. From this screen, click on **First Time Users** to begin the process. Even if you enrolled using the on-line system last year, you must click on First Time Users again this year.



Fill in all of the fields on this page:

- Social Security Number (first time users must enter their SSN)
- Company Key: **soc** (use all lowercase letters)
- Date of Birth

You will then be prompted to create your own user ID and password. Once you have created your ID and password, you will use these to login to the system, so note them for future use. After you have logged in, you will have access to the open enrollment homepage. From the open enrollment homepage, click **2005 Open Enrollment** to begin the process. Once inside the system, navigate using only the links within the system. DO NOT use your browser's navigation (e.g., the Forward or Back button).



The on-line system provides an intuitive, easy-to-use, step-by-step process. You will only have to make changes to the areas where you want changes. Click **Next** to continue through the system. After making all your necessary changes, you will have the opportunity to review your selections on a confirmation page. **Please print your confirmation as a record of your elections.**

If you have difficulties printing your confirmation, there is no printer available to print your confirmation, or you experience continued technical difficulties with the on-line system, please call your department's benefits or payroll staff for assistance.

Every State of Colorado public library provides free Internet access. Consult your phone book for the library nearest your location. In addition to public libraries, your department may have additional options available (check with your department's benefits or payroll office), and DPA has arranged the following options with the Colorado Community College System:

Colorado Community College System Classified Open Enrollment Locations Available October 18 – November 6, 2004

Agency	Address	Days Available	Times Available	Computers/Location
Colorado Community College System Office	9101 E. Lowry Blvd. Denver, CO 80230	Mon – Fri	8 am to 5 pm	HR Office/Room 158 9101 E. Lowry Blvd. Denver, CO 80230
Arapahoe Community College	5900 S. Santa Fe. Drive Littleton, CO 80160	Mon – Fri	8 am to 4 pm	Library 5900 So. Santa Fe. Littleton, CO 80160
Community College of Aurora	16000 E. Centre Tech Pkwy Aurora, CO 80011	Mon – Mon - Fri	9:30 am to 12 pm	HR Office, Room A207 16000 E. Centre Tech Pkwy Aurora, CO 80011
Community College of Denver	1111 W. Colfax Denver, CO 80217	Mon – Thur Fri Sat	8 am to 8 pm 8 am to 5 pm 8 am to 1 pm	Auraria Campus Auraria Tech Bldg. Computer Lab 1111 W. Colfax, Room 104 (across from the
Colorado Northwestern Community College - Craig	500 Kennedy Drive Rangely, CO 81648	Mon – Fri	8 am – 5 pm	Atrium 1st Floor – ALAP – Room 200 500 College Drive Craig, CO 81625
Colorado Northwestern Community College -Rangely	500 Kennedy Drive Rangely, CO 81648	Mon – Fri	8 am – 5 pm	Library- McLaughlin Bldg. 500 Kennedy Drive Rangely, CO 81648
Front Range Community College - Westminster	3645 W. 112th Ave. Westminster, CO 80031	Mon – Thurs Fri. Sat. Sun.	8 am to 9 pm 9 am to 5 pm 10 am to 5 pm 1 pm to 5 pm	College Hill Library 3705 W. 112th Ave. Westminster, CO 80031
Front Range Community College – Larimer	4616 So. Shields Fort Collins, CO 80526	Mon.& Wed Tues & Thurs Fri & Sat. Sun.	4 pm to 8 pm 10 am to 1:30 pm 1 pm to 5 pm 1 pm to 5 pm	Harmony Library 4616 So. Shields Fort Collins, CO 80526 (Corner of Harmony &
Northeastern Junior College*	100 College Drive Sterling, CO 80751	Mon – Thurs. Fri Sun	7:30 am -9:50 pm 7:30 am -4:20 pm 4 pm – 7 :50 pm	Monahan Library 100 College Drive Sterling, CO 80751
Otero Junior College	1802 Colorado Ave. La Junta, CO 81050	Mon – Fri	8 am to 5 pm	Wheeler Hall Library 1802 Colorado Ave. La Junta, CO 81050
Pikes Peak Community College – Centennial **	5675 So. Academy Blvd Colorado Springs, CO	Mon – Thurs. Fri Sat. Sun	8 am to 10 pm 8am to 4 pm 10 am to 3 pm 1 pm to 4 pm	Centennial Campus – A300 5675 So. Academy Blvd. Colorado Springs, CO 80906
Pikes Peak Community College – Rampart Range**	11195 Hwy 83 Colorado Springs, CO	Mon – Thurs. Fri. Sat. Sun	8 am to 10 pm 8 am to 4 pm 10 am to 3 pm 1 pm to 4 pm	Rampart Range – E203 11195 Hwy 83 Colorado Springs, CO 80921
Pikes Peak Community College -	100 Pikes Peak Ave. Colorado Springs, CO	Mon – Thurs. Fri Sat.	8 am to 10 pm 8am to 4 pm 10 am to 3 pm	Downtown Studio – D152 100 Pikes Peak Ave. Colorado Springs, CO
Pueblo Community College	900 West Orman Ave. Pueblo, CO 81004	Mon. – Fri	8 am to 7 pm	Library Academic Bldg., 1st Floor Pueblo, CO 81004
Red Rocks Community College	13300 W. 6th Ave. Lakewood, CO 80228	Mon - Thurs Fri Sat	9 am to 8 pm 9 am to 4 pm 10 am to 2 pm	Library 13300 W. 6th Ave. Lakewood, CO 80228
Trinidad State Junior College – Trinidad Campus	600 Prospect St. Trinidad, CO 81082	Mon – Thurs Fri Sat Sun	8 am to 9 pm 8 am to 5 pm 1 pm to 5 pm 5 pm to 9 pm	TSJC Campus Library 600 Prospect St. Trinidad, CO 81082
Trinidad State Junior College – Small Business Development Center	136 W. Main Trinidad, CO 81082	Mon – Fri	8 am to 5 pm	Small Business 136 W. Main Trinidad, CO

*$1 Computer Usage Fee
**State ID Required

Eligibility

State employees and their eligible dependents may receive group benefits as prescribed in the Colorado Revised Statutes and the State Benefits Plans chapter of the State Personnel Director's Administrative Procedures (Chapter 11). "Employee" does not include persons employed on a temporary basis. Individuals not meeting these requirements are not eligible to enroll in or be enrolled in any State group benefit plan. "Dependent" means an employee's legal spouse; each unmarried child, including natural children, adopted children, stepchildren, and foster children. Children are eligible through the end of the calendar year in which the child turns 19 years of age, for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage; each unmarried child 19 years of age through the end of the calendar year in which that child is no longer a full-time student in an educational or vocational institution, but no longer through the end of the month in which the full-time student turns 24 years of age, and for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage; or an unmarried child of any age who has either a physical or mental disability, as defined by the carrier, not covered under other government programs, and for whom the employee is a major source of financial support or for whom the employee is directed by court order to provide coverage.

Enrollment

To be covered under any State group benefit plan, employees must enroll within 31 days of their hire date or during the annual open enrollment period. To be covered under a State group medical, dental, and optional life insurance plan, eligible dependents must be enrolled within the same time frames that employees may enroll or within 31 days of an "eligible event."

The "eligible events" for enrolling dependents are:

- Marriage
- Birth
- Child placed for adoption
- Child returning to full-time student status
- Court decree requiring dependent coverage
- Placement of foster child
- Legal custody/guardianship of a child
- Child loses eligibility for Medicaid coverage
- Birth of a grandchild when parent is still an eligible covered dependent
- Unmarried child of any age who is medically certified as disabled by the carrier and dependent upon the employee as the major source of financial support no matter when the disability occurred.

Dependents are not eligible for enrollment in Basic Life/AD&D Insurance, Flexible Spending Accounts, Long-Term Disability, or Tax-Deferred Savings Plans.

When choosing the most appropriate health care plan, it is important to understand the common terms and phrases used by health care professionals and insurance companies.

Admitting Privileges: The right granted to a doctor to admit patients to a particular hospital.

Benefit: Amount payable by an insurance company or benefit plan to a claimant, assignee, or beneficiary when an insured suffers a loss.

Carve Out: The practice of excluding specific services or benefits from health insurance contracts so they can be managed separately. Mental health, pharmacy, and case management services are often "carved-out" of medical plans.

Case Management: A utilization management technique used to follow a patient's treatment for a specific condition that helps coordinate a number of health care services and helps ensure that individuals receive appropriate, reasonable services.

Claim: A plan participant's request to a benefit plan or insurer for the payment of certain benefits.

Coinsurance: Coinsurance refers to the percentage that an individual is required to pay for services, after a deductible is met. For example, the employee pays 20 percent toward the charges for a service and the insurance company pays 80 percent.

Consumer-Directed Health Care: A movement toward giving employees more of a voice in health care decisions as well as more financial responsibility for care. Consumer-directed (a.k.a. consumer-driven) plans typically combine an employer-funded, employee-directed health care savings account with a high deductible insurance plan.

Co-Payment: Co-payment is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HOMOs require a $25 "co-payment" for each office visit. Co-payments are not specified by percentages and usually cannot be applied to deductibles or out-of-pocket maximums.

Coordination of Benefits (COB): When an individual is covered by more than one plan, the Primary Plan pays without regard to the possibility that another plan may cover some expenses. The Secondary Plan pays after the Primary Plan and may reduce the benefits it would pay if it were primary, so that payments from all group plans do not exceed 100 percent of the total allowable expenses.

The State Dental plan is secondary if the employee's dependent has another dental plan.

Deductible: The amount an individual must pay for health care expenses before insurance (or a self-insured administrator) covers costs. Many health plans are based on yearly deductible amounts.

Defined Contribution Health Plan: A plan characterized by a fixed (e.g., flat-dollar) employer contribution that employees may use to purchase medical coverage. Such plans are the precursors of modern consumer-directed health care strategies.

Denial of Claim: An insurance company or plan or administrator finds that a request by an individual (or his or her provider) to pay for health care services is not covered and will not be paid.

Dependent: Generally the spouse or child of a covered individual. Can be any person who relies on, or obtains coverage through, a covered individual. Certain programs, such as the Dependent Care FSA, define dependent more narrowly when determining eligible expenses.

Disease Management: Programs designed to improve the health of persons with specific health conditions and to reduce use and costs associated with avoidable complications. Disease management programs commonly target chronic conditions such as diabetes, asthma, depression, cardiac care, pulmonary heart disease, low-back pain, and high-risk pregnancies.

Employee Assistance Programs (EAR): An employment-based health service program designed to provide early intervention and resolution of employee work-related or life problems (e.g., alcoholism, domestic violence, drug abuse) that affect job performance.

Exclusions: Prescriptions, procedures, or other services that are not covered by an individual's insurance policy.

Formulary: A listing of prescription medications that are covered by a health plan. A formulary often fosters the substitution of generic or therapeutic equivalent medications for more cost-effective treatment.

Health Care Decision Counseling: Services, sometimes provided by insurance companies or employers, that help individuals weigh the benefits, risks, and costs of medical tests and treatments. The goal of health care decision counseling is to help individuals make more informed choices about their health and medical care needs, and to help them make decisions that are right for the individual's unique set of circumstances.

Health Maintenance Organization (HMO): A prepaid medical group practice plan that provides a comprehensive predetermined medical care benefit package. HMOs are both insurers and providers of health care.

Indemnity Health Plan: Indemnity health insurance plans are also called "fee-for-service" plans. These are the types of plans that primarily existed before the rise of managed care (e.g., HOMOs and PROs) and are characterized by the use of deductibles and coinsurance and the absence of contracted providers. The patient typically chooses whichever doctor or hospital he or she wants to use.

Limitations: Conditions or circumstances for which benefits are not payable or limited, as detailed in an insurance policy.

Long-Term Care Policy: Insurance policies that cover specified services for a specified period of time. Long-term care policies (and their prices) vary significantly. Covered services often include nursing care, home health care services, and custodial care.

Length of Stay (LOS): A term of used by insurance companies, case managers, and employers to describe the amount of time an individual stays in a hospital or in-patient facility.

Managed Care: Health care programs that impose some controls on the utilization of health care services, providers, or the fees charged for such services. Managed care can be provided through HMOs, PPOs, and managed indemnity plans. The primary goal is to deliver cost-effective health care

without sacrificing quality or access.

Maximum Benefit Allowance or Covered Expenses: An amount customarily allowed for or covered for services and supplies which are medically necessary, recommended by a doctor, or required for treatment.

Maximum Out-of-Pocket Payment: The maximum amount of money a person will pay in addition to premium payments. An out-of-pocket payment is usually the sum of deductible and coinsurance payments.

Maximum Plan Limit: The maximum amount payable under a health plan often separated as three limits: defined, per cause, and all-causes maximums. Defined is the maximum amount the plan will pay for covered medical expenses. Per cause is the maximum limit for each separate injury or illness. All causes maximum applies to all covered expenses incurred during a specified period of time.

Open-ended HMOs: Also known as Point-of-Service (POS) plans, an HMO that provides benefits for medical care obtained from providers outside the HMO contracted network.

Out-of-Plan: This phrase usually refers to physicians, hospitals, or other health care providers who are considered non-network or outside the contracted network of an insurance plan (usually an HMO or PPO). Depending on an individual's health individual plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Outpatient: A person who visits a clinic or emergency room for health care without being admitted as an overnight patient.

Pre-Admission Certification: Also called pre-certification review or pre-admission review. The process of obtaining certification or authorization from a health plan for hospital admissions, surgery, or other procedures based.

Pre-Admission Testing: A plan benefit designed to help reduce the length of hospital stays by encouraging patients to get needed diagnostic services on an outpatient basis before a non-emergency hospital admission.

Pre-existing Condition: A medical condition of an insured person that existed prior to the issuance of his or her policy. Some plans may cover these conditions after a predefined waiting period, while others may permanently exclude coverage of the condition of the person.

Preferred Provider Organization (PPO): A group of hospitals and physicians that contract on a fee-for-service basis with employers, insurance companies, or third party administrators to provide comprehensive medical coverage. Using in-network providers and services allows more of an individual's costs to be covered; however, an individual can go out-of-network to receive care, but usually at a higher cost.

Primary Care Provider (PCP): The health care provider in a managed care plan who is responsible for coordinating all care for an individual patient, from providing direct care services to referring the patient to specialist and hospital care. PCPs usually include Internists, Family Practitioners and OB/GYNs.

Provider: Provider is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as the hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

Reasonable and Customary Fees: The average fee charged by a particular type of health care practitioner within a geographic area. The term is used often by medical plans as the maximum amount of money they will approve for a specific test or procedure. When out-of-network fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider may reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Risk: The chance of loss, the degree of probability of loss, or the amount of possible loss to the insuring company or the employer under a self-funded plan. For an individual, risk represents such probabilities as the likelihood of surgical complications, medications' side effects, exposure to infection, or the chance of suffering a medical problem because of a lifestyle or other choice. For example, an individual increases his or her risk of getting cancer if he or she chooses to smoke cigarettes.

Second Opinion: It is a medical opinion provided by a second physician or medical expert to confirm or deny the opinion of a physician who provides a diagnosis or recommended course of treatment. Individuals are encouraged to obtain second opinions whenever a physician recommends surgery or presents an individual with a serious medical diagnosis.

Second Surgical Opinion: It is an opinion provided by a second physician, when one physician recommends surgery to an individual - also a cost management strategy that encourages or requires plan participants to obtain the second opinion of another physician after a doctor has recommended a non-emergency or elective surgery to be performed.

Self-Insurance: A method of financing an employee benefit plan in which the sponsoring organization (i.e., employer) retains the risk. Many self-insured plans purchase reinsurance (stop-loss) coverage to protect against individual or aggregate losses in excess of a specified amount.

Short-Term Disability: An injury or illness that keeps a person from working for a short time. The definition of short-term disability (and the time period over which coverage extends) differs among insurance companies and employers. Short-term disability insurance coverage is designed to protect an individual's full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working. Usually provides a percentage of wages for a specified period of time.

Waiting Period: A period of time when you are not covered by insurance for a particular condition.

Medical Plans

Anthem Liberty EPO/Centennial PPO.....303-831-2384
1 800-843-5621

Kaiser Permanente HMO.....303-338-3800
1 800-632-9700

San Luis Valley HMO.....719-589-3696
1 800-475-8466

Dental Plans

Delta Dental.....1 800-489-7168

Flexible Spending Accounts (FSAs)

Central/ASI Customer Service.....1 800-659-3035

Automated Account Balances & Reimbursements InfoLine 125.....1 800-366-4827
www.asiflex.com

Life Insurance & Disability

Standard Insurance Company..... 1 800-252-5577
www.standard.com

Tax Deferred Savings Plans

457 Deferred Compensation Plan - Great-West/BenefitsCorp.....1 800-838-0457
www.colorado457.com

PERA & PERA 401(k) Plan.....303-832-9550
1 800-759-7372
www.copera.org

403(b) Annuity Plan.....Contact Campus Benefits Office

401(a) Defined Contribution Pension Plan for Elected & Appointed Officials

General Information - Employee Benefits.....303-866-3434
1 800-719-3434

ICMA-RC Vantage Line.....1 800-669-7400

VALIC.....1 800-448-2542

Colorado State Employee Assistance Program

CSEAP.....303-866-4314
1 800-821-8154

Employee Benefits

Department of Personnel & Administration
Division of Human Resources - Metro Denver 303-866-3434
1 800-719-3434
www.colorado.gov/dpa/dhr